STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155444	A. BUILDING 01 B. WING	08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	3720 N NORWOOD RD HUNTINGTON, IN46750

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/03/11 Facility Number: 000463 Provider Number: 155444 AIM Number: 100290910 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Norwood Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000)	K0000	The facility shall ensure compliance with Life Safety and State Licensure requirements. This plan of correction shall serve as the facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitiute admission or agreement by the provider to the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely becasue it is the required by the provisions of federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and areas open to the corridor. The facility has a capacity of 88 and had a census of 60 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/08/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0046 SS=F	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency light fixtures of at least 1½ hour duration was tested annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on every required	K0046	K 0046Corrective action for residents affected: The annual emergency light test was completed and documented on 8/9/11 by the Maintenance Supervisor.Other resident's having the potential to be affected: [same]Measures to ensure practice does not reoccur: The Maintenace Supervisor will complete and document the annually the emergency light test. Completion will be	08/09/2011

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	battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on observation with Director of Maintenance on 08/03/11 at 10:55 p.m., a battery operated emergency light was observed in the emergency generator housing. Based on an interview with the Director of Maintenance at the time of observation, he stated he did not conduct an annual test of the battery operated emergency light. 3.1-19(b)		documented on the "Weekly [and annually] Generator Check".This corrective action will be monitored by: The Administrator shall review the monitoring logs monthly for six months and complete an annual check by 8/9/12. Compliance will be reviewed by the QA Committee for one year.	

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K0056 SS=E	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure complete coverage was provided for 1 of 1 station 2 janitor's closets in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. This deficient practice could affect any resident near the station 2 janitor's closet. Findings include: Based on an observation with the Director of Maintenance on 08/03/11 at 11:00 a.m., there was a partial wall extending sixteen inches from the ceiling in the station 2 janitor's closet obstructing the sprinkler head.	K0056	K0056Corrective Action for resident's affected: The "bulkhead" in the station 2 Janitor's Closet was removed on 8/15/11 by the Maintenance Supervisor. There are no further barriers/obstructions to the sprinkler head.Other resident's having the potential to be affected: The Maintenance Supervisor completed a facility wide inspection on 8/18/11 to ensure there were no other sprinkler head obstructions.Measures to ensure practice does not reoccur: The Maintenance Supervisor shall complete monthly inspections of all sprinkler heads to ensure there are no barriers. Any barriers found, will be corrected immediately.This corrective action will be monitored by: Quarterly the contracted fire safety service shall monitor for complaince. The results shall be reported to the QA Committee for 6 months.	08/18/2011

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	The sprinkler head would not provide complete coverage for the entire janitor's closet. Measurements were provided by the Director of Maintenance at the time of observation. 3.1-19(b)			
K0130 SS=E	OTHER LSC DEFICIENCY NOT ON 2786 Based on record review and interview, the facility failed to ensure 3 of 5 water heaters had a current inspection certificate to ensure the water heater was in safe operating condition. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of residents. Due to lack of information about which two water heaters had been inspected and which three had not, the exact number of residents affected could not be determined. Findings include: Based on record review with the	K0130	K0130Corrective Action for resident's affected: All 5 water heaters had been inspected on 5/4/11 by David Scherer, Inspector, Indiana Division of Fire and Building Safety; however, 3 of 5 inspection reports had not been forwarded to the facility at the time of the Life Safety Survey. Copies for all 5 water heaters are now available at the facility.Other resident's having the potential to be affected: [same]Measures to ensure practice does not reoccur: The Maintenance Supervisor shall ensure the inspections are completed and reports received in a timely manner.This corrective action will be monitored by: The Administrator shall monitor and report his findings to the QA Committee to ensure compliance.	08/15/2011

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	Director of Maintenance on 08/03/11 from 10:55 a.m. to 12:30 p.m., all five water heaters had a Certificate of Inspection which expired on 04/28/11. Based on interview with the Director of Maintenance at 12:30 p.m., he could only provide documentation to show two of the five water heaters had paid invoices. Due to lack of information provided on the invoices, it could not be determine which two water heaters would receive current certificates. 3.1-19(b)			